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The No Surprises Act: How Did We Get Here?

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The *No Surprises Act* (NSA) is the latest chapter in the ongoing struggle between insurance payers and physicians. But today's challenges result from the compounding laws and regulations that have emboldened payers and steadily shifted the balance of power.

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Practices Positioned Patients at the Center of a Payment Dispute Between Payers and Physicians

Historically, physicians have been able to negotiate in-network contracts with insurance companies to ensure fewer denials, lower patient cost-share, and prompt payments. However, emergency medicine (EM) contracts are unique from those of other medical specialties in that there is no control over patient volume or payer mix, and there is no ability to change staffing hours or services to offset any decreases in payer reimbursement.

These dynamics change the calculus for in-network EM contracts, and in recent years, it has become common for EM physicians to remain out-of-network (OON) when reasonable terms can't be reached.

The common practice in this OON scenario was for the insurance companies to pay the allowed amount, and the guarantor (generally the patient) would owe the remaining amount—a practice known as balance billing.

But, over time, insurance companies started shifting more of the cost onto the cost-sharing amount owed by the patient. The theory was that if patients were aware of the "cost," they would be more thoughtful in seeking care. However, this increase in cost-sharing led to public frustration over the dollar amount of these balance bills.

The *Affordable Care Act* (ACA) went into effect on January 1, 2014, and attempted to address the frustration of high cost-sharing using the greatest-of-three (GOT) payment standard. The expectation was that the GOT standard would ensure that payers couldn't pay an unreasonably low amount for OON care, and patients would be protected from

unreasonably high cost-sharing bills. However, the ACA did not include an outright ban on Balance Billing.

Narrow Networks Help "Reduce" Health Care Costs

The ACA helped accelerate the shift to narrow networks as a way to reduce health care costs. However, the unintended consequence of these narrow networks was that more patients were surprised to learn they were OON when seeking unplanned care. And this unexpected lack of coverage eventually led to a rise in *surprise billing*, i.e., when a patient seeks care at an in-network facility and is seen by an OON physician.

This phenomenon led several states to enact bans on surprise billing. However, this patchwork approach by individual states only had a limited effect because most Americans are covered under employer-sponsored health plans—many of which are governed by the federal ERISA statute applicable to self-funded insurance plans.

So, pressure started to build for Congress to establish its own federal standard. And a deal was eventually reached after years of negotiations and compromises between insurance payers, physicians, and lawmakers. The NSA was signed into law at the end of December 2020.

The NSA helps protect patients from unexpected coverage gaps by ensuring that their cost-sharing amount is the same for OON care as it would otherwise be for in-network care.

To achieve this, the law created the concept of the "recognized amount," which allows insurance payers to calculate the cost-sharing amount for OON care. And to determine the recognized amount, payers must calculate the qualifying payment amount (QPA), the median contracted rate for the service (as of January 31, 2019, adjusted for inflation).

However, payers quickly shifted from using the QPA as a tool to determine the patient cost-sharing amount and instead started using the QPA as the de facto value for the service. This was a subtle nuance, but it would eventually become the

Trojan horse in the current struggle between insurance payers and physicians

The NSA Helped Remove Patients From the Middle of These Payment Disputes, but the Regulations Governing This Law Remain Entangled in Debate

Once the NSA became law, the Departments of Labor, Treasury, and Health and Human Services (i.e., the tri-agencies) went into their rule-making period to draft the framework of rules and regulations that would govern the NSA when it took effect on January 1, 2022.

The first sign of trouble came when Congress published its interim final rule in October 2021, which focused on the independent dispute resolution (IDR) process and included controversial language on how the QPA should be used and calculated.

The interim rule instructed IDR entities to presume that the QPA was the appropriate payment amount for OON services. But this immediately led to backlash from the physician community, who argued that the rule would unfairly tip the scales in favor of the insurance payers. The tri-agencies had disregarded the law's intent, which specifies that all statutory factors should be considered in every case (including the physician's level of training, market share, acuity of the patient, teaching status, good faith efforts, or prior contracted rates).

This disproportionate weight given to the QPA in the interim rule led to the first in a series of lawsuits from the Texas Medical Association (TMA).

- TMA I was filed in October 2021; it argued that the interim final rule gave too much weight to the QPA and that nothing in the law stated that arbiters should give added weight to any one factor in their final payment decision. A federal judge ruled in favor of TMA on Feb. 23, 2023, and the tri-agencies agreed to address this language in their final rule.

- TMA II was filed in September 2022 in response to the final rule, which again gave disproportionate weight to the QPA by asking arbiters to consider the QPA first and provide a written explanation of any other factors considered outside the QPA. On Feb. 6, 2023, a federal judge again ruled in favor of TMA. It ordered all IDR entities to pause their rulings through mid-March 2023, when new guidance was finally published.

- TMA III, filed in November 2022, argued that certain aspects of the QPA calculation allowed insurance companies to artificially deflate its value (e.g., the inclusion of ghost rates or unrelated specialties and services, among other issues). On Aug. 24, 2023, a federal judge ruled in favor of TMA, and the federal IDR process was again temporarily paused. The IDR portal has since re-opened, and HHS has filed an appeal in this case.

- TMA IV was filed in January 2023 in response to a sharp increase in IDR administrative fees. Physicians argued that the increase from $50 to $350 would make it cost-prohibitive for some groups to access IDR, especially since batching requirements prevent the efficient bundling of claims (e.g., in emergency medicine, separating claims by type, payer, and service can lead to a high volume of small-dollar batches). On Aug. 3, 2023, a federal judge ruled in favor of TMA and vacated the fee increase as well as part of the batching requirements (that services and items be described by the same service code). However, this decision found only that the rules were passed without following proper procedure. And on Dec. 18, 2023, the tri-agencies issued their revised rules for IDR fees with the proper 30-day notice-and-comment period (as required by statute). The revised fees include an Administrative Fee of $115; and an IDR Entity Fee ranging from $200-$850 for single determinations and $268-$1,173 for batched determinations (up to 25). These new rules went into effect on Jan. 22, 2024.

- Another related lawsuit is the Daniel Haller case, in which a physician argued that the NSA violates certain constitutional rights. However, EDPMA filed an amicus

brief that supported neither party in this case, instead expressing concern about how this misinterpretation could affect the viability of existing common-law claims and the scope of IDR. The initial ruling favored HHS, but an appeal is currently underway.

These lawsuits have been an important tool in helping physicians balance the playing field, but they have unfortunately also added to the delays and confusion that have plagued the NSA.

Problematic Changes in Payer Behavior Have Also Intensified the Negative Impact on Physicians, Resulting in an Overwhelming Current of Payment Disputes

When the NSA was established, many physicians believed this new law would have only a limited impact due to its specific focus on OON medical services. But, when the law went into effect, physicians noticed an abrupt change in payer behavior. Many insurance payers lost interest in maintaining in-network status. Some payers sent cancellation letters to physicians in their network, while others walked away from active in-network negotiations altogether.

This was a curious shift in payer behavior, but not surprising when you consider the lower payments, favorable rules, and lack of enforcement that payers could enjoy with OON claims under the NSA.

A recent EDPMA study on payer behavior found that post-NSA OON payments decreased by an average of 32% compared to pre-NSA OON payments for clinically identical services. Data also shows that payers routinely fail to comply with QPA disclosure requirements and often ignore claims in the open negotiation period.

These hardball tactics have pushed more physicians into OON status, leading to an avalanche of payment disputes that quickly overwhelmed the IDR system.

The Absence of Regulatory Enforcement Has Resulted in a Pattern of Payer Non-Compliance

In April 2022, regulators anticipated that about 22,000 disputes would be filed under the Federal IDR process. But the tri-agencies reported that more than 490,000 disputes were filed between April 2022 and June 2023 (with about 61% of those disputes remaining unresolved by December 2023).

IDR entities simply can't keep up, and a massive backlog has continued to build as they struggle with the volume and complexity of these payment disputes—especially as regulators have continue to fumble their guidance for the IDR process.

Payer non-compliance also seems to run rampant in the IDR process, with EDPMA data showing that in the NSA's first year, 75 percent of payers failed to make an actionable offer during IDR, while 87 percent of payers failed to pay in accordance with their IDR rulings. These trends were also persistent in a recent report from the Government Accountability Office (GAO), which reported that non-payments were the biggest reason for complaints during their audit period.

The Effect of These NSA Regulations and Payer Non-Compliance is Particularly Harmful to the Practice of Emergency Medicine

Emergency departments are especially impacted by these NSA regulations. Emergency physicians are already adjusting to shrinking Medicare reimbursement and the loss of public health emergency funding, and the growing trend of hospital boarders that has led to fewer available emergency department beds and more patients leaving without being seen by a physician.

Emergency physicians have been feeling the squeeze of shrinking reimbursement. Now, they're also dealing with the threat of insurance payers manipulating the value of their services.

According to the GAO report has, emergency departments are the most common place of service for Federal IDR disputes. And the reality is that all of these issues are starting to reach a breaking point as we continue to erode our nation's health care safety net.

The Physician Community Has Continued to Advocate For Change and Lawmakers Are Starting to Listen and Voice Their Own Concerns

Groups such as ACEP and EDPMA have done a great job of collecting data on payer behavior and mobilizing the physician community to speak out—and lawmakers are now paying attention.

In a subcommittee hearing earlier this year, House Republicans blamed HHS Secretary Xavier Becerra for the lackluster rollout of the NSA.

- "This process is a failure and a failure because of poor planning on HHS," said Rep. Michael Burgess, R-Texas. "… [then] to turn around and blame providers for your department not being prepared for the volume of claims just doesn't square with me."

Rep. Larry Bucshon, MD (center, yellow tie), listened to ACEP members' concerns about the NSA at a dinner at the 2023 ACEP Leadership & Advocacy Conference. (Click to enlarge.)

- Rep. Larry Bucshon, MD, R-Indiana, added, "We recently heard in [IDR] situations that even though providers are winning those cases, we still don't have insurance companies paying after they have lost."

- Rep. Mariannette Miller-Meeks, R-Iowa, also called on Mr. Becerra to address the recent legal setbacks surrounding the IDR process and use of the QPA. "We

feel the comments we have gotten back from HHS have been less than satisfactory," she said.

House Democrats have also expressed concern, including ranking member Richard E. Neal, D-MA, who made comments during a recent hearing on the implementation of the NSA. Rep. Neal lamented that the "implementation of this law has strayed from Congress's approach, especially as it relates to the dispute resolution process."

The NSA Was the Product of Years of Bipartisan Legislative Work, but Its Implementation Has Fallen Short of What the Law Envisioned

We've been able to shine a spotlight on this flawed administrative process, but change takes time and persistent effort. Physicians should continue working with groups such as ACEP and EDPMA to push for reasonable initial payments, an effective, independent, dispute resolution, and better enforcement of the law.

We have a unique story to share as physicians, constituents, and health care experts—and we have to be persistent and proactive in sharing those stories with lawmakers.

Dr. Brault (@DrABrault) is the chairperson of the EDPMA board of directors and serves on the ACEP/EDPA Surprise Medical Billing Task Force Steering Committee.